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ABSTRACT

The occurrence of breast cancer creates psychosocial stress for both the patient and her family. Because of the threat to the patient's life and frequent disfigurement that results from breast cancer, interpersonal relationships, particularly the marital/sexual relationship and the mother/daughter relationship, are adversely affected. The related literature suggests that while many families may experience growth and greater closeness due to the disease, a significant number experience relational difficulties. Much of the literature stresses how crucial communication, acceptance, and support from family members are to the recovery and well-being of the patient. A study of 36 breast cancer patients between the ages of 35 and 82 who sought help from a social service agency supports the notion that many victims of the disease are not receiving the kind of support they need from family members. A number of women reported being unable to talk to their mates about the cancer and experiencing conflict with adult daughters, often ending in a severing of relations. Of those who were widowed or divorced, many relied on neighbors or church members for support. Evidence from the related literature and the study suggests that the needs of the family must be considered along with those of the patient. (Fifty-one references are included.) (JC)

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The Impact of Breast Cancer
on Interpersonal Relationships

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ABSTRACT

The Impact of Breast Cancer on Interpersonal Relationships

The occurrence of breast cancer creates psychosocial stress for both the patient and her family. Because of the life-threatening aspect and disfigurement often resulting from the disease, interpersonal relationships are affected. The effects have often been reported to be deleterious, particularly to the sexual/marital relationship.

This study identifies the interpersonal problems cited in the existing research and discusses communication theories that help to elaborate on the theoretical perspectives already provided by researchers to explain the complex nature of family responses to breast cancer. The study also includes data from case records of breast cancer clients and family members who sought the help of a social service agency. These data demonstrate how family problems arise from relational rules and patterns that have been established and are manifested in family responses and coping strategies. Findings of this study support the claims of other researchers that family members' psychosocial needs must be considered along with those of the patient. This suggests a need for further examination of the spouse's responses as well as identification of the perceptions and responses of children, particularly teenage daughters and sons.

The responses of family members to the diagnosis and treatment of breast cancer are crucial factors in the patient's recovery. Along with the patient, the family members themselves undergo a number of changes that create psychosocial stress (Buckley & Michaels, 1974; Cobliner, 1977; Ervin, 1973). For example, they may experience emotional shock as a result of the illness. This causes disruption in their daily living and additional demands upon their time and energy (Baudry & Weiner, 1968; Rose, 1976). Another stressful task for the family is the restructuring of their roles, which is necessary to maintain the integrity of the system (Lewis, Ellison, & Woods, 1985; Mailick, 1979; Vettese, 1981). These role shifts can create problems in relationships particularly when personal goals and responsibilities in jobs, school, and activities cannot be fulfilled (MacVicar & Archbold, 1975; Wellisch, Fawzy, Landsverk, Pasnau, & Wolcott, 1983).

Family members may become overtaxed in their handling of the details of daily living (Barckley, 1970). The family stability and autonomy weakens if leadership and initiative are lacking as the family attempts to meet these additional demands on them (Giacquinta, 1977). Furthermore, when the treatment of the disease results in loss or mutilation of a body part which involves the patient's feminine pride and sexuality, the marital relationship and sexual intimacy may be seriously affected (Kent, 1975; Lamb & Woods, 1981; Maguire, 1975; May, 1981; Renneker & Cutler, 1952)). The children may also have strong emotional reactions to their mother's surgery (Lewis et al., 1985; Wellisch, 1985). While some families are able to handle these changes and emerge stronger from their experience, other families are immobilized (Lewis, 1983; Lichtman, 1982).

Research on the psychosocial effects on family members has been primarily concerned with cancer in general or with families experiencing the terminal illness of a member. The focus has more often been on the individual (Miller & Nygren, 1978) and in some cases on the spousal dyad (Chekryn, 1984) and only incidentally on the family. Although the impact of cancer on family members has been observed and reported in numerous studies, there is little systematic documentation of the specific problems that families experience with one another nor have the communicative strategies employed to cope with breast cancer been studied. Because there are specific interactive issues associated with cancer of the breast, a number of researchers have urged investigation of families affected by this disease; several have recently undertaken this task (Grandstaff, 1976; Lewis et al., 1985; Lichtman, 1982; Pederson & Trigg, 1985; Wellisch, 1985).

From the systems perspective, any stressful or critical event which occurs to one member of a family has an effect upon other members. The effect may be more profound on some members than on others and each may employ different methods of coping. Individual coping patterns have been studied from a number of viewpoints. White (1974), for example, who adopts a clinical psychological perspective, postulates that three variables are involved in adapting to change: securing adequate information; maintaining internal organization, especially the level of self-esteem; and maintaining autonomy, which implies looking to the future. From a social psychological point of view, Mechanic (1974) views adaptation as a function of the fit between the external demands of stress and the person's resources. The specific components of successful adaptation, then, consist

of the individual's skills and capabilities for dealing with the social and environmental demands, the motivation to meet those demands, and the ability to maintain "psychological equilibrium" (p. 33).

One of the major determinants in successful adaptation is the support of individuals and groups who give encouragement, assurance of worth and help in alleviating anxiety. The spouse and other members of her family are in a position to provide the support for the breast cancer patient. If relationships prior to cancer have been supportive, the family is at an advantage. If relationships have been fragile before the cancer, however, coping strategies may be misunderstood and destructive. Because the health care professionals spend considerable time with patients and their families during the critical phase of the diagnosis and treatment, they are attuned to the physical, psychological, and emotional stresses that can pull the family apart (Christ, 1983).

The purpose of this study is to identify and elaborate upon issues that impact upon the interpersonal relationships between family members who experience breast cancer. To achieve this goal, the paper will provide (1) a review of the literature pertaining to the effects of breast cancer on interpersonal relationships, (2) a discussion of theoretical perspectives that help to explain the complex effects of breast cancer on relationships, (3) data derived from case records of breast cancer patients which provide evidence of relational difficulties, and (4) a discussion of results.

REVIEW OF THE LITERATURE

Studies of the effects of breast cancer on the family examine the spousal dyad and the parent-child dyad. The studies on the relationship between spouses have focused on changes on the sexual relationship and

reactions to changes in wife's physical appearance. The parent-child relationship is also affected by breast cancer. The studies that examine this aspect of the family have identified problems with the child's functioning (e.g., school, illness), developmental factors as well as changes in the relationships. This review will illustrate these specific findings in detail.

Studies Related to Effects of Breast Cancer on the Spousal Dyad

Many studies of breast cancer have focused on the spousal/partner dyad. The results suggest that the spouse's reaction, particularly when disfigurement results, and the condition of the marital relationship prior to the cancer are key factors in the patient's recovery (Bloom, Ross, & Burnell, 1978; Cobliner, 1977; Ervin, 1973; Lichtman, 1982). Woods (1975), for example, observed that if a woman perceives herself as mutilated, and therefore sexually unacceptable, she may withdraw from sexual intimacy and thus trigger her mate's rejection. The spouse may also have a decreased desire for sexual intimacy (Lamb & Woods, 1981). For some couples, the sexual relationship after mastectomy may become one of the most difficult areas of adjustment (Ervin, 1973; Kent, 1975; Maguire, 1975; May, 1981). Wabrek and Wabrek (1976) observed that mastectomy does not enrich a relationship but, rather, it threatens a marriage. They noted that even when the marriage is "good," it will not easily survive the trauma.

A number of case studies have examined the impact of breast cancer on the dyad. A pilot study of 41 women illustrates how mastectomy may adversely affect the marital relationship. In this study, the woman's main concern was for her mate's attitudes; her own abilities to accept the loss of a breast depended on this reaction (Witkin, 1978). Maguire, Lee,

Bevington, Küchemann, Crabtree, and Cornell (1978), who studied 96 women with mastectomies, found that even when patients had had a satisfactory sex life before the surgery, they frequently reported problems in sexual functioning after surgery. One third of the breast cancer clients in a pilot study by Pederson and Trigg (1985) reported that sexual satisfaction had declined after their treatment whereas 75% of their mates judged it to be the same. In parallel studies (Jamison, Wellisch, & Pasnau, 1978; Wellisch, Jamison, & Pasnau, 1978) done from the perspectives of both the mastectomy patients and their mates, the effect of the surgery on the sexual relationships from the male perspective as not clear but for 24.2% of the women, it was negative. A study of 49 post-mastectomy clients (Woods & Earp, 1978) found that the importance the woman placed on her marital-sexual relationship and the quality of the relationship were associated with her sexual adaptation. Those who were most satisfied with the relationship perceived that their husbands understood their needs and problems and that they could confide in their husbands. Although the effect on sexual intimacy is not clear-cut, the research indicates that the relationship undergoes a high risk of deterioration when mastectomy has been performed. The specific nature of partner concerns has not been pursued.

The spouse's reaction to a change in physical appearance is a major concern. Grandstaff (1976) observed that the most crucial time for the couple is when the husband views the scar. Should he choose not to look at his wife's surgery, his response may result in her withdrawal and his counter withdrawal. On the other hand, if his viewing of the scar evokes a spontaneous aversive reaction, he may in turn evoke feelings of rejection

in his wife (Bard & Sutherland, 1955). Husbands in Lichtman's study (1982) stated that they were less concerned about their wives' disfigurements than their well-being; only 10% of the men had bad reactions to the mastectomy scar. However, several husbands admitted to being turned off by it.

Several explanations for the variation in spousal reaction to the disfigurement have been suggested. Socially desirable motives may prompt denial of negative reactions (Lichtman, 1982). Another explanation is that couples who have enjoyed stable marriages prior to the mastectomy may grow closer and more caring as a result of the cancer experience (Grandstaff, 1976).

The Effect of Breast Cancer on the Parent-child Dyad

The parent-child dyad is also affected by the occurrence of breast cancer. Although the impact on this relationship has received little attention (Wellisch, 1985), several researchers have noted trauma in children (Klein, 1971; Kriss, 1982; Lichtman, 1982; Pederson & Trigg, 1985). Personality changes in the patient, her hospitalization and the uncertainties associated with the cancer can have a strong impact on the children of breast cancer patients. Pederson and Trigg (1985), in their pilot study of families of breast cancer patients, found that the reactions of offspring varied from what appeared to be detachment or denial to extremely emotional responses. One young boy had had frequent symptoms of illness and had not wanted to go to school. Daughters of two other patients reported difficulty in concentration and in controlling their emotions. In the Lichtman study (1982) the mother-child relationship remained the same in most cases and tended to deteriorate only in the case of a poor prognosis or invasive surgery.

Because the developmental level of the individuals is related to family functioning (Cohen & Wellisch, 1978; Gray-Price & Szczeany, 1985), perceptions and responses will be quite different for each member. Younger children's fears focus on the family unit and the portent of "bad things happening"; the young school child shows more preoccupation with outside activities and wants specific information about mother's condition whereas adolescents are torn between gaining independence and giving their mothers emotional support (Lewis et al., 1985). Because the risk for female relatives has been recognized, the impact on daughters of breast cancer patients is significant. Although a number of factors determine the degree of risk, the possibility of eventually having breast cancer herself can have a strong influence on the daughter's relationship with her mother (Wellisch, 1985).

Role reversal in the mother-daughter relationship may occur as a result of breast cancer. This occurs when the mother becomes very dependent on her daughter because she fears that she may be abandoned by her offspring (Worby & Babineau, 1974). At the same time the daughter identifies with her mother and realizes the possibility of experiencing the same fate (Klein, 1971; Kriss, 1982). Not only is the adolescent daughter vulnerable but the relationship between an adult daughter and her mother often changes after breast cancer. The older mother's reaction could range from the extreme of an hysterical response to ignoring the cancer. These reactions can result in avoidance, hostility and a myriad of conflicting emotions.

Grandstaff (1976) observed that teenage sons (about 15 or 16 years old) also appeared to have unusually difficult adjustments to their mothers' loss of a breast. The results of her study also suggest that relationships with children can become stronger if communication is open

and feelings are shared. More research is needed in this area to reveal the more specific and long range effects of breast cancer on the children (Lewis, 1983).

Some researchers report that the impact of breast cancer strengthens the relationships between family members. As already noted by Grandstaff (1976) and Lichtman (1982), some breast cancer patients and their families have found a positive dimension in the cancer experience. One-third of the breast cancer patients interviewed by Pederson and Trigg (1985) reported that they had grown closer as a result of the experience. However, two of the subjects who withdrew from the study subsequently were divorced. For couples in the Lichtman study (1982), most husbands and wives reported that they became more appreciative of one another.

In reviewing the literature on the effect of breast cancer on families, it becomes apparent that, even though many families can undergo a process of growth resulting in closer, more satisfying relationships, a significant number experience relational difficulties. Interpersonal challenges and conflicts often accompany the adjustment that members must make. Evidence of the relational impairment which can be a consequence of the illness and earlier unresolved conflicts often comes to the attention of agencies and support groups, such as Reach to Recovery, which endeavor to help the patient as well as the family. The few studies that concern problems which have directed attention to family members suggest that services be targeted more specifically for them. As Lewis et al. (1985) express it, the family is "falling through the cracks" (p. 211).

THEORETICAL PERSPECTIVES

To explain how breast cancer affects the interpersonal relationships in the family, a delineation of theoretical concepts is useful. Several theories that are explanatory of how patients manage or control the stress related to their cancers are developmental, crisis, attribution, equity, and phenomenological theories. Goffman's concept of self-presentation in dealing with the stigma of disfigurement is also relevant. While no one theory sufficiently explains the effects of this disease-related stress upon the relationships in a family structure, each of these does help to illustrate the problem. A number of factors contribute to the complexity of familial relationships. These factors include family composition (ages of the couple, the length and stage of the marriage as well as the ages and developmental stages of each offspring), resources, personal orientations, special needs, self-esteem, perceptions and experiences of each member. Additional factors are the patterns the family has established for solving problems and for communicating and responding to one another's needs. These complex factors will influence how each member and the family as a whole reacts and attempts to deal with the physical, cognitive and emotional stresses of breast cancer and how their relationships will be affected.

Pertinent to the effect of a crisis event upon close interpersonal relationships are theories which explain responses to a stress or in terms of individual internal needs, the dimensions of relational interaction, how the event is perceived and the role of communication in a life-threatening crisis. The following section of this paper will explicate these theories and their role in explaining the impact of breast cancer on families.

Crisis Theory

Crisis theory can be used to explain the overall impact of cancer on family relationships (Parad & Caplan, 1965). This theory is based on family life styles, intermediate problem-solving mechanisms and need-response patterns. The family life style is a combination of stable patterns of interaction, family values and roles. Intermediate problem-solving mechanisms represent how the family copes with stress. The need-response patterns are the ways the members perceive, respect and satisfy one another's individual needs within the bounds of family resources.

According to this theory, sociocultural factors influence three phases (perception, respect, and satisfaction) of the response patterns. The critical point or peak of a crisis may become the turning point which stimulates family members to mobilize their hidden strengths and use new adaptive responses which may later become a part of the family's lifestyle. Conversely, they may fall back on the same established problem-solving mechanisms. Thus, how they respond to individual needs at that critical time will determine their future direction as a family. The established lifestyle of the family affords or fails to afford opportunities for the development of a more stable equilibrium.

As the family works through the new solutions required by a crisis, such as breast cancer, they may either neglect or exploit each other's needs. These basic needs that come into focus include love, the suitability of role models, the balance between support and independence in regard to tasks as well as the balance between freedom and control of instinctual expressions. The breast cancer experience disrupts the

family's normal patterns of functioning and intensifies individual needs and responses which are manifested in verbal messages and interpersonal behaviors. The various ways in which members exhibit egocentric and/or empathic behaviors as they move through the crisis reflect their family lifestyles (values, roles, and communication patterns). Poor leadership, dysfunctional internal communication or an inefficient organization structure may result in failure to augment the group effort to regain equilibrium or in dissipation of their effort. Individual members may also displace their guilt, feelings of anger, or resentment toward the patient and their anxiety concerning her welfare to one member. This exploitation of a member, of course, leads to relational difficulties.

Psychological, Relational, Perceptual, Attribution,
and Communication Theories

Whereas crisis theory can explain the family's adjustment to breast cancer by examining response patterns through phases of adjustment, other theories help to explain dimensions of the interpersonal process. This process includes the nature of individual needs and how those needs are perceived by others. Schutz's theory of interpersonal needs will be used to illustrate how behavior is directed toward the fulfillment of our internal needs for others. The interpersonal process also involves how one person imagines the thoughts and feelings of others and how relationships are defined and negotiated. Laing's theory of perception and attribution provides an explanation of the difficulty in perceiving accurately the internal state of another and the consequence of perception on behavior toward the other. Millar and Rogers' concept of relational communication will be used to explain the negotiation process of defining and

communicating a relationship. Furthermore, the interpersonal process reflects how behavior and feelings affect and are affected by communication. Two theoretical models will be used to illustrate the role of communication in a life-threatening crisis. The first, Wortman and Dunkel-Schetter's model, explains the communication dilemma and problems that may result from breast cancer. The second model (Nimocks, Connell, & Roan, 1986) provides an understanding of the effect of terminal illness (sometimes the case in breast cancer) on communication as well as the therapeutic effect of communication when openness and self-disclosure are achieved.

Schutz's (1966) theory of fundamental interpersonal relations orientation, explains an interpersonal situation from the perspective of an individual's internal needs for other people. This theory includes four postulates. The first postulate describes three needs, properties of which closely paralleled biological needs in many ways. An individual is oriented to behave toward others in ways which will bring about satisfactory attainment of these needs which are: inclusion (the degree to which a person needs the company of, or association, with other in order to feel worthwhile); affection (the need for emotional closeness and intimacy); and control (the need for having or not having control over the other or a feeling of competence and responsibility). These needs can vary in individuals between the extremes of giving and receiving one's needs in relation to the level of the other person's needs.

The second postulate states that a person's interpersonal behavior originates in early childhood through interaction with parents and will tend to remain constant in relationships throughout life. The third and

fourth postulates relate to compatibility (the ability to coexist harmoniously in a way that interpersonal needs are mutually satisfied) and the tendency of interpersonal relationships to follow the same sequence as they are formed and developed. Thus, Schutz's theory explains how behavior is directed toward fulfilling individual needs of inclusion, affection and control through our relationships with others.

This focus on internal needs does not, however, allow for choice, change or adjustments in ongoing interactions (Littlejohn, 1983), nor does it explain the discrepancies that occur between persons in their perceptions of the other's thoughts and feelings. Therefore, other theories are useful in explaining how a person perceives the inner states of another, a phenomenon that may be crucial to the relationship in a life-threatening context where a high level of emotional ambiguity, fear, and uncertainty exists.

Interpersonal perception and attribution constitutes another perspective of relationships that is applicable to understanding the impact of cancer on the family. Laing's (1966, 1967, 1969; Laing, Phillipson, & Lee, 1980) concepts of direct perspectives and metaperspectives in the process of perception are relevant to understanding communicative behavior. This theory posits that one perceives the behavior of another person and judges or interprets that behavior according to an interpersonal set of criteria that may be quite different from the intended meaning or perspective of the other. Because experiences and criteria are private and often below the level of consciousness, each must imagine what the other thinks and feels. The privacy of experiences and the instructions for handling incoming data which have been programmed in early life account for

inaccuracies of perceptions and the thoughts and feelings that one person may attribute to the other. Moreover, interpersonal interaction may take a number of forms that may be either positive or harmful. Positive forms include complementarity and affirmation of one's identity. Negative results of interaction include disconfirmation, collusion or mutual self-deception, false or untenable position, and attributions or injunctions which tell a person how to behave or feel. A multitude of factors such as value systems and similarities or dissimilarities in experience will affect perceptual accuracy, the extent to which experiences are shared and, thus, the health of the relationship. Perceptual and attribution perspectives, such as Laing's theory, give us insight into the growth or deterioration of relationships that result from the process of perceiving behavior and inferring what another is thinking, feeling and perceiving. For example, the wife thinks the husband does not perceive her as sexually desirable and she behaves accordingly. This shows how our perceptions of how others perceive us can influence, positively or negatively, our interaction with them.

The theories of Schutz and Laing help in explaining the internal complexities that individuals bring to a relationship but the question of how individuals define and negotiate their relationship remains to be examined. The conceptual development of relational communication outlined by Millar and Rogers provides some understanding of this process.

In their theoretical concept of relational control, Millar and Rogers (1976) illustrate the reciprocal nature of the negotiation process by which persons define themselves and their relationship. Their theory elaborates upon three transactional dimensions of social relationships: control,

trust, and intimacy. The first dimension, control, is characterized by a rigid-flexible continuum and a stable-unstable continuum. The more control exerted by one person, the more rigid the relationship; the more control alternated between the couple, the more flexible their relationship. The second characteristic of control, stable-unstable, refers to the consistency of the control messages.

Components of the second dimension, trust, are vulnerability, reward dependability, and confidence. The pattern of vulnerability varies according to the frequency with which one is in a vulnerable position whereas reward dependability varies with the degree of dependency one has on another in a relationship. Confidence is the degree to which one person has confidence in the other's trustworthiness. Thus, in a trusting relationship, one is vulnerable, dependent and confident that the other will not exploit that trust.

The final dimension of this theory, intimacy, depends on the degree of attachment, or need for another. In highly intimate, nontransferable relationships the partners receive self-confirmation from one another. In transferable intimacy, one or both partners may have other persons who provide ego confirmation. Couples who have low role discrepancy, or fewer communication differences (inequities) in their dyadic system, will have more supportive statements, more transactions and fewer silences in conversations than couples who have high role discrepancy. Moreover, there is more role discrepancy in marriages of shorter term (11 years or less) than longer term marriages (12 to 26 years).

The theory of Miller & Rogers is particularly relevant in explaining the negotiation process of redefining the relationship that the disruption of breast cancer often necessitates. When a spouse experiences a serious illness, the dimensions of control, trust and intimacy come into sharp focus. Both spouses have a loss or change in control because of the life-threatening aspect of breast cancer. The loss, of course, is greater for the patient who must acquiesce to the counsel and directives of health care providers. In her relationship with her spouse the balance of control/power shifts, at least for the duration of her recovery. The nature of control that couple has established will determine the ease of difficulty with which the relationship is maintained or renegotiated. Moreover, her vulnerability makes dependency, trust, and confidence in her spouse particularly important to their relationship as well as her recovery. If disfigurement results from treatment, sexual intimacy is at risk. The couple with low role discrepancy will be more apt to provide ego confirmation for one another. For this reason the greater attachment that a couple of longer term marriages may have developed enables them to maintain a more supportive relationship than often occurs in shorter term marriages.

The theories reviewed so far are applicable to understanding the impact of the crisis event of breast cancer on a family as a whole and the relationships within that unit. Crisis theory helps to explain how the established lifestyle of the family influences member's responses to one another's needs. Interpersonal dependency on one another to meet internal needs is explained by the Schutz theory. The complexities of interpreting the perceptions and attributing feelings, thoughts, and intentions to

another are explainable in terms of Laing's theory. Finally, the theoretical framework of Millar and Rogers gives insight into how members define and communicate their relationship. Two additional theoretical models focus on the patient and significant others and the communicative dilemma which occurs in the case of life-threatening illness.

Wortman and Dunkel-Schetter (1979) developed a model which focuses on the cancer patient's intense need for support, the reactions of significant others and their beliefs regarding appropriate behavior. The conflict in their negative feelings that are aroused by the illness and their beliefs that they should maintain a cheerful facade results in unintentional harmful behaviors (ambivalence and anxiety) which lead to avoidance of physical contact and open communication. The patient interprets the discrepant verbal and nonverbal messages as rejection. This occurs when the patient is most in need of support and may react to the perceived rejection with lowered self-esteem. She may either exaggerate problems to elicit attention or minimize them to present a brave face. Thus, her behaviors encourage further dependency and rejection.

In effect, then, communication problems result from (1) the patient's fear and uncertainties, needs for clarification and support, and barriers to support; (2) others' feelings and reactions toward the patient, their beliefs concerning appropriate behavior and their actual behavior; (3) the impact of others' behaviors; and (4) the patient's attempt to solve the dilemma. If she expresses her feelings, she incurs avoidance; if she pretends she is fine, she will gain some support. Because neither of these alternatives is satisfactory, the patient may vacillate between them, sometimes putting on a good face, and sometimes confronting others with her

pain and anxiety. This may result in a lack of support from those close to her when she is most in need of their support. The consequences may be an impairment of those relationships and a victimization of the patient with a resulting decline in her ability to cope.

Wortman and Dunkel-Schetter have several implications of this model. First, therapeutic intervention may stop the process of relational impairment and isolation by including the family in a therapy program designed to make both patients and family members aware of the problems and to encourage communication. Intervention would also increase the contact of patients with others who have experienced cancer. In addition, health care professionals can provide more information about the effective consequences of cancer, inquire about the patient's social network and encourage open discussion of feelings and concerns. Finally, health care providers can be made aware of their own ambivalent and negative feelings toward patients and can receive constructive feedback as well as assistance in coping with the distress that accompanies and affects their interactions with cancer patients.

A second theoretical model which focuses on communication and the terminally ill has application for this study. The model (Nimocks et al., 1986) is based on the assumptions that discussion of feelings can help in accepting and coping with the stress which is experienced in difficult and unfavorable situations and that feelings will be expressed candidly only when it is safe, appropriate, and unlikely to bring harm to self, others, and their relationships. The relational rules that govern the communication in threatening situations will affect the amount of openness of disclosure between the patient and significant others. Moreover, the

level of relational intimacy will determine the amount and candidness as well as the content of the communication. A life-threatening illness creates anxiety which heightens the communication apprehension that interactants experience. Friends and family members and health care professionals often avoid the patient or restrict conversation to chit-chat rather than discuss feelings and fears. The theorists also posited that this communication apprehension decreases verbal output. An increase in open communication and disclosure of feelings will have a cathartic effect which will allow for maintenance or stabilization of a relationship, the assurance of caring environment, the acceptance of the disease, and in some cases, the acceptance of impending death.

Thus far in this paper a review of the literature has established the need for further investigation of the effects of breast cancer on patient and family relationships. Although research reports of the frequency of deleterious effects of breast cancer on close relationships range widely--from 10 to 50% of the cases according to Lichtman (1982)--there is sufficient evidence of relational problems. There is also wide agreement about the need for further investigation and intervention.

Secondly, in an effort to find explanations for the effects on relationships, several theories and models have been examined. In concert, these theoretical perspectives give insight into the reactions, interactions, and personal dilemmas that the breast cancer patient and her family experience as well as the adaptive behaviors they may employ. Although there is some overlapping in the variables included in the various theories, the complex nature of the cancer experience cannot be explained on one theory.

CASE STUDIES ILLUSTRATING RELATIONAL PROBLEMS

To further illustrate effects of breast cancer on the family, a case study was conducted. In this study the records of breast cancer patients who had sought help in a Midwestern metropolitan agency which serves cancer patients and families who seek assistance for nonmedical problems were examined for information concerning family dynamic issues. Although the questions asked by the agency are not structured to determine family interaction patterns and relationships, the records contain disclosure of interpersonal conflict and factors related to interpersonal functioning. The number of times the social worker saw the client, the reluctance of the client to reveal personal information and other factors account for the variable amount and nature of the information in records.

Subjects

Sixty-seven case records of breast cancer clients who had sought assistance of the agency were examined. Because of insufficient data or inaccessibility of records, 36 cases were selected for this study. Thirty-three of those clients had a mastectomy, one a lumpectomy, one had been diagnosed too late for surgery. Another had delayed surgery because of the spouse's illness. The deaths of four of those clients had been reported. One of those who had other serious health complications had committed suicide. The deaths of two other clients were imminent.

Demographic data were inconsistently reported (see Table 1). The ages ranged from 35 to 82 years with a mean age of 57.3 years. Although five of the patients had not reported their marital status, it was apparent from family composition that all of them had been or were married. Fifty percent were living with their spouses, almost 28% were separated or

divorced. Five spouses were themselves in a depressed, disabled or senile state so they could be of little help to their wives. The incomes of only 39% of the subjects were reported, but of those incomes that were reported, over 28% of the subjects were in an income level of under \$10,000 a year. Four said specifically that they needed financial help.

Table 1
Age, Marital Status and Income of Women
Having Had Breast Cancer Surgery

N = 36

Age			Marital Status			Income		
	N	%		N	%		N	%
31-40	6	16.7	Married	18	50.0	\$1000-\$5000	6	16.6
41-50	6	16.7	Divorced or			\$5000-\$10000	4	11.2
51-60	8	22.2	Separated	10	27.8	\$10000-\$15000	3	8.3
61-70	7	19.4	Widowed	3	8.4	\$15000-\$30000	0	0.0
71-80	7	19.4	Unreported	5	13.8	\$30000-\$35000	1	2.8
81-	1	2.8				Unreported	22	61.1
Unreported	1	2.8						
Total	36	100%		36	100%		36	100%

Family Interaction

Comments which the clients or family members had made to social workers regarding communication and relationship difficulties indicated that 75% were experiencing problems as a result of the breast cancer. As an example, one young widow, whose death was imminent, was very concerned about the care of her children. However, because she was unable to discuss her cancer or her feelings with them, she prevailed upon the social worker to come to her home and explain the situation to them. The social worker obliged but was unable to elicit any response or interest in her mother's condition from the 13-year-old daughter. Eight of the clients indicated a need for someone with whom they could talk in order to get information and reassurance. There were no data concerning the interpersonal communication in nine families.

The inadequacy of emotional support was also evident. Although there were instances of clients who had at least one family member upon whom they could rely for support, two had no family support at all (see Table 2). They relied upon church members, a public health nurse or neighbors. In only one case was the support judged by the social worker to be good. Almost no mention was made of communication with the spouse. In two cases clients said they could not talk with their husbands about the cancer.

Table 2
Family Interaction: Support,
Communication and Family Relationships

N = 36

Support			Communication			Family Relationships		
	N	%		N	%		N	%
Good	1	2.8	Good	0	0.0	Not Close	2	5.5
Fair	7	19.4	Difficult	27	75.0	Do not discuss feelings	4	11.2
Poor	27	75.0	Unreported	9	25.0	Strained	5	13.9
No Data	1	2.8				Conflict/hostile	7	19.4
						Estranged	5	13.9
						Not discernible	13	36.1
Total	36	100.0		36	100.0		36	100.0

The complexity of relational problems in these families was evident. Thirty-one percent reported that they were not close, could not discuss feelings and had strained relationships. Nineteen percent admitted to family conflicts in which hostility existed. For example, an adult daughter professed to hate her mother's second husband who was himself very distressed by the client's pain and the task of caring for her at home as well as the daughter's resentment of him. In another instance the social worker reported that an adult daughter was ill-tempered, impatient and resentful of her mother's dependence which the son-in-law explained was a long-standing struggle between mother and daughter. In five cases (13.9%) the family members had either moved out of the home and/or ignored the ill

member. In the case of a divorced client whose former spouse had remarried a younger woman, the 17-year-old daughter had gone to live with her father and had nothing to do with her ill mother. The daughter of another patient, who was in need of financial and emotional support, had also severed relations with her mother.

Unresolved conflicts and other traumatic events complicated the adjustment for 55% of the clients. In one instance the death of the spouse had caused the postponement of the mastectomy. Other critical events included the death of children and parents, in some cases with cancer; loss of employment; and concomitant physical ailments such as diabetes, epilepsy, and hypertension. One client had lost the use of her arm from the cancer surgery.

In attempting to discern the response styles and coping mechanisms used by clients (see Table 3), it was apparent that they frequently employed ego-defense mechanisms and that most responses and coping patterns were negative. For example, one patient, who kept conversation on the level of small talk, took the attitude that "whatever happens, happens." Another, having characteristically used denial to cope with the crisis in her life had left her husband when he suffered war injuries and was attempting to ignore her own illness. Still another had chosen to isolate herself. Only 8.3% of the clients coped in a constructive (realistic, rational, calm) manner. Of the 19 (53%) family members whose interaction was clearly identifiable, only 2 (5.5%) of those appeared to be giving support to the client. The others (47.5%) were either unable to be supportive or reacted to the client's needs with resentment, anger, rejection or by ignoring her. Data from the case records concerning family dynamics and interpersonal relationships support the need for giving attention to families where breast cancer occurs.

Table 3
Coping Strategies of Patients and Families
N = 36

Patients			Families		
	N	Z		N	Z
Realistic	2	5.5	Supportive	2	5.5
Rational, calm	1	2.8	Unsupportive	2	5.5
Optimistic	1	2.8	Angry	2	5.5
Angry	4	11.2	Disoriented	2	5.5
Depressed	9	25.0	Disorganized	1	2.8
Denying	5	13.9	Ignoring	5	13.8
Fearful	2	5.5	Resentful	1	2.8
Hopelessness	2	5.5	Rejecting	3	8.3
Lonely, rejected	2	5.5	Keeping busy	1	2.8
Helplessness	1	2.8	Not clear	17	47.5
Withdrawal	1	2.8			
Not Clear	6	16.7			
Total	36	100.0	Total	36	100.0

DISCUSSION

In the review of the literature and in the data presented above it is apparent that many families have relational problems as a result of breast cancer. Patients and family members have reported that the disease creates certain stresses on their personal relationships. These include feelings of aloneness, sometimes avoidance of the patient, communication problems, difficulty with children, emotional tensions over the patient's inability to fulfill role functions and resentment of the demands made by the patient's illness. They have also reported grievances concerning inadequate information or impersonal treatment given them by health care providers.

In the study of breast cancer clients seeking agency assistance, 75% reported poor communication and relational difficulties with family members. Open hostility may have culminated a long-standing conflict. In some cases, clients had little or no contact with family members; relations had been severed. Conflict with daughters was evident in several cases and, for married clients, spousal support appeared to be inadequate or poor. Some who were widowed, divorced and/or living alone relied for support on church members, a nurse or neighbors.

In the case of breast cancer the relational difficulties may be related more specifically to the patient's body image especially when treatment consists of extensive surgery and to her partner's response to the disfigurement. Although many couples develop a closer bond and become more appreciative of one another, the mate's aversive reaction to a surgical wound or scar may initiate or accelerate the deterioration of a

relationship. If his response evokes no feelings of rejection in the patient, the adjustment for her is made easier. Even though many couples have reported no change in their marital and sexual satisfaction after mastectomy, surgeons tend to view the loss of a breast as a threat to a marriage.

Although little is known about how children react to their mother's breast cancer, the studies that have examined the effect on them have identified responses that correspond to the child's developmental stage. Small children fear the loss of mothers whereas the younger school child's preoccupation with outside activities limits interest to information about the illness. The adolescent is caught between being independent and being supportive. Teenage daughters, realizing their own as well as their mother's vulnerability, have reported highly emotional reactions. Some display hostility. Teenage sons may also experience unusually difficult reactions.

The different reactions of patients and family members and the subsequent directions that the relationships will take, have been attributed to several factors. The length and the status of the marriage appear to be significant. The longer a couple has been married, the more stable the marriage tends to be and, thus, more resistant to the relational stresses of illness. The quality of the marital relationship prior to the illness also appears to influence the adaptation, particularly the sexual intimacy which is often the most difficult adjustment after the illness. The patient's ability to confide in her mate as well as her perception that he understand her needs and problems will help her in maintaining a satisfactory relationship. In addition, the stage of the disease and the

prognosis will be powerful factors in relational adjustment to the disruptions created by breast cancer.

Two other determinants of the family's relational adjustment appear consistently in the literature: the family's ability to talk openly and the need for supportiveness. Open communication has been emphasized in helping the patient and family to understand what they are experiencing and to maintain their family stability. Finally, and probably most important, is the reassuring support of family, friends, and significant others. Especially important to the recuperating patient is the maintenance of a satisfactory close bond with her spouse. If unsupportive, his behavior is interpreted as rejection and, for her, a loss of self-esteem occurs. The spouse and other family members, in turn, need the support of one another.

Because no one theory seems adequate to explain the effects that a life-threatening event such as breast cancer can have upon the patient and members of her family and their relationships, a number of theoretical perspectives have been explored. The dimension of relationships derive in part from the family composition: the spouses' ages, length of marriage or remarriage, and number and ages of children. Other factors that contribute to the complexity of relationships consist of each member's resources, personal orientations which include special needs, self-esteem, perceptions, and experiences. The characteristic manner with which the family has solved problems and individual coping behaviors as well as patterns of communication will influence how the family meets the challenge of crisis. As stated earlier, many families, in mobilizing their latent strengths, develop more effective behaviors for meeting problems. What

explains why some families fail to rally together, even become rejecting, hostile, estranged?

The crisis theory of Parad and Caplan which emphasizes the importance of the family structure, patterns of interaction, responses to one another's needs and typical problem-solving mechanisms helps to explain why family bonds either deteriorate or strengthen. A family characterized by poor leadership, inefficient organizational structure and dysfunctional communication may be unable to unify their efforts and may even make one member a scapegoat for their failure.

The needs of each member, which Schutz has identified as inclusion, affection and control, may be unmet in a time of crisis. The focus of attention on one member to the exclusion of others can result in resentment and other unsupportive feelings and behaviors. The loss of control, the sense of helplessness over the situation experienced by each member, especially the patient, can also lead to conflictual interaction. It follows, then, that an understanding of the internal needs of each family member gives insight into the negative feelings and behaviors that may be evoked when those needs, intensified by uncertainty and fear, are unfulfilled.

Whereas Schutz's theory explains the vulnerability of the patient and spouse in their needs for affection and inclusion, it does not account for the discrepancies that may occur in their perceptions of one another's thoughts and feelings. The patient who withdraws may do so to parry the rejection she perceives in her spouse who perceives her to be rejecting him. Laing's theory of perception and attribution provides an understanding of this withdrawal/counter-withdrawal phenomenon, especially

when disfigurement has occurred. For each spouse the internal criteria and programmed instructions for interpreting incoming data may be quite different. Added to that potential for inaccuracy are the intense emotions each is experiencing.

In addition to the process of perception and attribution the couple negotiates their relationship in terms of control, trust and intimacy, according to the theoretical perspective of Millar and Rogers. If the relationship is a trusting one, the patient, who is the most vulnerable and dependent, will be confident of her husband's support. How the control has been exerted in their relationship will determine the degree of flexibility and stability and, in turn, affect their adaptability. On the intimacy level, if they have few communication differences, they will communicate more openly and be more supportive/confirming of one another. Thus, how they have defined their relationship explains why some couples may have difficulty in accepting the traumatic experience and in maintaining a close relationship.

The perspectives thus far do not explain the unintentional contradictions in verbal and nonverbal behaviors that create a dilemma for the patient and her significant others. The model of Wortman and Dunkel-Schetter focuses on unintentional harmful behaviors that reflect the beliefs regarding appropriate behavior and the patient's intense need for support. Because of the persistent idea that one should not talk about the serious matters that concern cancer patients, significant others maintain a cheerful facade. At the same time their negative feelings toward the illness prompt their avoidance of physical contact and open communication with the patient. Their contradictory behavior evokes feelings of

rejection in her. In attempting to solve the dilemma she may vacillate between presenting a brave face and exaggerating her problems to gain attention. This may result in declining support from family and declining coping ability in the patient.

Concurrently, relational rules will govern the openness of disclosure between patient and significant others. A model focusing on communication with the terminally ill posits that the level of relational intimacy will determine what the patient and significant others will discuss as well as the extent of the discussion and their candidness. Moreover, the increased apprehension will decrease the amount, intimacy, and congruency of verbal output. If, however, the patient and family feel that the situation is safe, appropriate, and unlikely to harm self, others, and their relationships, the disclosure will be open. Furthermore, the cathartic effect of the disclosure of feelings will allow for maintaining and stabilizing the relationships. This theoretical perspective offers some explanation of a family's ability to realize positive results from the cancer experience and why others do not.

The studies on the family's reaction to breast cancer and members' abilities to resolve the problems created by the illness give somewhat contradictory impressions. A preponderance of studies emphasize the widespread negative and dysfunctional consequences for both the patients and families. More recent studies (Grandstaff, 1976; Lichtman, 1982) have indicated that breast cancer more often becomes a positive experience which enriches family relationships than the literature in general has indicated. Nonetheless, with the projected cases of breast cancer approaching 1 to 10

women in the United States, the number of families who experience relational difficulty as a result of the illness is significant. .

More research is needed to identify the problems and the factors that will enable families to cope with breast cancer more successfully. The impact on spouses and children, especially teenagers, should be investigated. The mother-daughter relationship offers compelling reasons for further research.

Even those studies which have reported the positive dimension advocate intervention to help families understand the illness, its effects on them and the patient, and their family structure. Intervention can also help them to understand their emotional responses and provide support as well as information for additional support from sources outside the health care profession.

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